1. Inpatient Hospital Services

All inpatient admissions to an acute care/general hospital or rehabilitative hospital will be allowed up to four (4) days of service per admission when determined inpatient care is medically necessary. On the fifth day of hospitalization, if the physician determines the patient should not be discharged on the fifth day of hospitalization, the hospital may contact the **Quality Improvement** Organization (Arkansas Foundation for Medical Care, Inc.) and request an extension of inpatient days. The **Quality Improvement** Organization (**QIO**) will then determine medically necessary days. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. Medically necessary inpatient days are available to individuals under age 1 without regard to the four day limit and extension procedures required under the plan. Additionally, effective for dates of service on or after November 1, 2001, a benefit limit of 24 days per State Fiscal Year (July 1 through June 30) is imposed for recipients age 21 and older. No extensions will be authorized. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program.

Inpatient hospital services required for pancreas/kidney transplants, **liver/bowel transplants** and skin transplants for burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program. Refer to Attachment 3.1-E, Pages **2,** 4 and 6.

2. Inpatient Hospital Services

All inpatient admissions to an acute care/general hospital or rehabilitative hospital will be allowed up to four (4) days of service per admission when determined inpatient care is medically necessary. On the fifth day of hospitalization, if the physician determines the patient should not be discharged on the fifth day of hospitalization, the hospital may contact the **Quality Improvement** Organization (Arkansas Foundation for Medical Care, Inc.) and request an extension of inpatient days. The **Quality Improvement** Organization (**QIO**) will then determine medically necessary days. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. Medically necessary inpatient days are available to individuals under age 1 without regard to the four day limit and extension procedures required under the plan. Additionally, effective for dates of service on or after November 1, 2001, a benefit limit of 24 days per State Fiscal Year (July 1 through June 30) is imposed for recipients age 21 and older. No extensions will be authorized. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program.

Inpatient hospital services required for pancreas/kidney transplants, **liver/bowel transplants** and skin transplants for burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program. Refer to Attachment 3.1-E, Pages **2,** 4, and 6.

Revised: **December 3, 2004**

State/Territory: ARKANSAS

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The Arkansas Medicaid Program covers Corneal Transplants, Renal Transplants, Heart Transplants, Liver Transplants, Non-Experimental Bone Marrow Transplants and Lung Transplants for eligible Medicaid recipients of all ages. Pancreas/Kidney Transplants, **Liver/Bowel Transplants** and Skin Transplants for Burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

Corneal Transplants

Corneal transplants require prior authorization. Medicaid will pay for hospitalization, physician services and follow-up care when associated with corneal transplants. Covered benefits include the acquisition and preservation of the organ from a cadaver donor. Corneal transplants are subject to the same inpatient hospital, outpatient and physician benefit limits as all other covered inpatient, outpatient and physician services.

Renal Transplants

Renal transplants require prior authorization. Benefits are provided for the following services related to renal transplantation:

- Hospitalization and physician services for the removal of the organ from the living donor.
- Harvesting of the organ for renal transplant from a cadaver donor is reimbursed through the hospital cost settlement process.
- Transportation and preservation of the organ from a living or cadaver donor.
- Hospitalization and physician services for transplanting kidney into the receiver.
- Follow-up care.

Renal transplants are subject to the same inpatient hospital, outpatient and physician benefit limits as all other inpatient, outpatient and physician services for both donor and receiver.

Heart Transplants

Heart transplants require prior authorization. Benefits are provided for the following services related to heart transplantation:

- Procurement (harvesting) of the organ from a cadaver donor. Cost will be included in the hospital charges.
- Hospitalization and physician services for transplanting the heart into the receiver.
- Post-operative care until discharged from the hospital.

Liver **and Liver/Bowel Transplants**

Liver **and liver/bowel** transplants require prior authorization. **Liver/Bowel transplants are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program.** Benefits are provided for the following services related to liver **and liver/bowel** transplantation:

- Hospitalization and physician services for the removal of the organ from a living donor.
- Procurement (harvesting) of the organ from a cadaver donor. Cost will be included in the hospital charges.
- Hospitalization and physician services for transplanting the liver **and liver/bowel** into the receiver.
- Post-operative care until discharged from the hospital.

Heart, Liver **and Liver/Bowel** Transplants are not subject to the established benefit limits for inpatient hospital services described elsewhere in the State Plan. Services excluded from the inpatient benefit limit are those services provided from the date of the transplant procedure to the date of discharge. The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES **Revised: December 3, 2004**

---

1. Inpatient Hospital Services

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

In accordance with Section 1902(s) of the Social Security Act, we do not impose dollar limits on any inpatient hospital services for children under age one (or children that are hospitalized on their first birthday). This includes the $675.00 upper payment limit, the TEFRA rate of increase limit, the customary charge upper limit or the $150,000 **bone marrow** transplant limit. This applies to all inpatient hospitals.

Effective for claims with dates of service on or after July 1, 1991, all acute care hospitals with the exception of Pediatric Hospitals, Arkansas State Operated Teaching Hospitals, Rehabilitative Hospitals, Inpatient Psychiatric Hospitals and Out-of-State Hospitals, will be reimbursed based on reasonable costs with interim per diem rates and year-end cost settlements, with an upper limit of $584.00 per day.

Effective for claims with dates of service on or after April 1, 1996, all acute care hospitals with the exception of Pediatric Hospitals, Arkansas State Operated Teaching Hospitals, Rehabilitative Hospitals, Inpatient Psychiatric Hospitals and Out-Of-state Hospitals will be reimbursed based on reasonable cost with interim per diem rates and year-end cost settlements, with an upper limit of $675.00 per day. The upper limit was established taking the 90th percentile of the cost based per diems using their 1994 year end cost reports. This does not include the hospitals listed above as exceptions.

Effective for claims with dates of service on or after January 1, 1997, the upper limit of $675.00 per day will be applied to Arkansas State Operated Teaching Hospitals. The upper payment limit will apply to allowable costs; except GME payments will not be subject to the upper limit. Effective for cost reporting periods ending on or after June 30, 2000, the upper limit of $675.00 per day will no longer be applied to Arkansas State Operated Teaching Hospitals.

Arkansas Medicaid will use the lesser of cost or charges to establish cost settlements. If the lesser of cost or charges exceed the upper limit payment times total hospital Medicaid days, then the upper limit payment times the total hospital Medicaid days will be used to calculate the cost settlement. Effective for dates of service on or after July 1, 1991 thru March 31, 1996, the upper limit payment

1. Inpatient Hospital Services (Continued)

Direct medical education costs, including graduate medical education costs, are reimbursed based on Medicare reasonable cost rules in effect prior to the effective date of the September 29, 1989 rule.

TRANSPLANT SERVICES

A. In-State Acute Care/General Hospitals, All Bordering City Hospitals and All Out-of-State Hospitals

1. Corneal, Renal and Pancreas/Kidney Transplants

Inpatient hospital services required for corneal, renal and pancreas/kidney transplants are reimbursed in the same manner as other inpatient hospital services.

2. Bone Marrow Transplants

Interim reimbursement for bone marrow transplants will be 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed. Reimbursement will not exceed $150,000. Reimbursement includes all medical services relating to the transplant procedure from the date of admission for the bone marrow transplant procedure to the date of discharge. Both the hospital and physician claims will be manually priced simultaneously. If the combined total exceeds the $150,000 maximum, reimbursement for each provider type will be decreased by an equal percentage resulting in an amount which does not exceed the maximum dollar limit.

3. Other Covered Transplants

Hospital services (does not include organ acquisition) relating to other covered transplant procedures (does not include corneal, renal, pancreas/kidney and bone marrow) are reimbursed at 45% of submitted charges. Reimbursement includes all allowable medical services relating to the covered transplant from the date of the transplant procedure to the date of discharge. Transplant hospitalization days in excess of transplant length of stay averages must be approved through medical review. Transplant length of stay averages by each transplant type will be determined from the most current written Medicare National Coverage Decisions.

Inpatient hospital days prior to the transplant date will be reimbursed in accordance with the applicable State Plan methodology for the hospital type in which the transplant is performed.

Readmissions to the same hospital due to complications arising from the original transplant are reimbursed the same as the original transplant service at 45% of submitted charges. All excess length of stay approval requirements also apply.

1. Inpatient Hospital Services (Continued)

A. In-State Acute Care/General Hospitals, All Bordering City Hospitals and All Out-of-State Hospitals (Continued)

3. Other Covered Transplants (Continued)

Reimbursement for the actual organ to be transplanted (organ acquisition) will be at (a) 100% of the submitted organ invoice amount from an outside organ provider organization or (b) reasonable cost with interim reimbursement and year-end cost settlement. The hospital has the choice of using either method. If (a) is used, the provider will submit a copy of the invoice for the organ acquired and Medicaid will reimburse 100% of the invoice amount and no additional amounts will be reimbursed to the hospital. If (b) is used, an interim amount will be reimbursed to the hospital and a year-end cost settlement will be calculated. The interim amount reimbursed and the year-end cost settlement will be calculated in a manner consistent with the method used by the Medicare Program for organ acquisition costs.

B. In-State Pediatric Hospitals and Arkansas State Operated Teaching Hospitals

1. Corneal, Renal and Pancreas/Kidney Transplants

Inpatient hospital services required for corneal, renal and pancreas/kidney transplants are reimbursed in the same manner as other inpatient hospital services.

2. Bone Marrow Transplants

Interim reimbursement for bone marrow transplants will be 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed. Reimbursement will not exceed $150,000. Reimbursement includes all medical services relating to the transplant procedure from the date of admission for the bone marrow transplant procedure to the date of discharge. Both the hospital and physician claims will be manually priced simultaneously. If the combined total exceeds the $150,000 maximum, reimbursement for each provider type will be decreased by an equal percentage resulting in an amount which does not exceed the maximum dollar limit.

3. Hospital services provided by In-State Pediatric Hospitals and Arkansas State Operated Teaching Hospitals relating to other covered transplant procedures (does not include corneal, renal, pancreas/kidney and bone marrow) are reimbursed in the same manner as other inpatient hospital services with interim reimbursement and final cost settlement. Reimbursement includes all allowable medical services relating to the covered transplant from the date of the transplant procedure to the date of discharge. Transplant hospitalization days in excess of transplant length of stay averages must be approved through medical review. Transplant length of stay averages by each transplant type will be determined from the most current written Medicare National Coverage Decisions.

Inpatient hospital days prior to the transplant date will be reimbursed in accordance with the applicable State Plan methodology for the hospital type in which the transplant is performed.

Readmissions to the same hospital due to complications arising from the original transplant are reimbursed the same as the original transplant service. All excess length of stay approval requirements also apply.

C. Recipient Financial Services

The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

1. Inpatient Hospital Services (Continued)

Effective for claims with dates of service on or after July 1, 1994, hospitals in bordering cities will be reimbursed based on reasonable costs with interim per diem rates and year-end cost settlements, with an upper limit of $584.00 per day.

Effective for claims with dates of service on or after April 1, 1996, all hospitals in bordering cities will be reimbursed based on reasonable cost with interim per diem rates and year-end cost settlements, with an upper limit of $675.00 per day. The upper limit was established taking the 90th percentile of the cost based per diems using their 1994 year end cost reports as explained on Attachment 4.19-A, Page 1.

Effective for claims with dates of service on or after July 1, 1994 thru March 31, 1996, the upper limit payment of $584 will be applied. Effective for claims with dates of service on or after April 1, 1996, the upper limit payment of $675 will be applied.

Effective for claims with dates of service on or after March 1, 1999, hospitals located in Springfield, Missouri will qualify to be designated as a bordering city hospital and will be reimbursed based on reasonable cost with an interim per diem rate and year-end cost settlement. The upper limit of $675 will be applicable.

The following cities which are located within a fifty (50) mile trade area are considered bordering cities: Poplar Bluff, Missouri; Springfield, Missouri; Greenville, Mississippi; Poteau, Oklahoma; Memphis, Tennessee and Texarkana, Texas.

All other reimbursement information contained in Attachment 4.19-A, Pages 1 through 3, pertains to bordering city hospitals.

The TEFRA base year will be the first full cost reporting period beginning on or after July 1, 1991.

1. Inpatient Hospital Services (Continued)

Pediatric Hospitals (Continued)

Refer to Attachment 4.19-A, Page **3 and 3a,** for the reimbursement methodology for **transplant services**.

Arkansas' method of reimbursing malpractice insurance for pediatric hospitals will be a simple calculation made outside the cost report and the result added back on to the Medicaid settlement page of the report. The calculation would apply a Medicaid utilization factor based on cost to the portion of total malpractice expense (91.5%) which is reimbursed for Medicare on worksheet D-8 of the cost report. The remaining 8.5% remains on worksheet A of the cost report and flows through to be reimbursed like any other administrative cost. The final result would be to reimburse malpractice for Medicaid as though all malpractice expense remained on worksheet A and simply flowed through the cost report.

Direct medical education costs, including graduate medical education costs, are reimbursed based on Medicare reasonable cost rules in effect prior to the effective date of the September 29, 1989 rule.

3. Reimbursement for Inpatient Hospital Services for Children Under Age One (or Children that are Hospitalized on Their First Birthday)

Medically necessary inpatient hospital services furnished to children under age one (or children that are hospitalized on their first birthday) will be exempt from any dollar limits on any inpatient hospital service.

Inpatient hospital services **(excluding other covered transplant services for In-State Acute Care/General Hospitals, all Bordering City Hospitals and all Out-of-State Hospitals)** for these individuals will be cost settled separately from all other Medicaid recipients and no dollar limits will be applied.

Arkansas Medicaid will not consider these costs in the Medicare TEFRA rate of increase limit computation.

5. Physicians' Services (continued)

Reimbursement for physicians' services for bone marrow transplants is included in the $150,000 maximum as described in Attachment 4.19-A. Procedures will be manually priced based on professional medical review. The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

Reimbursement for physician's services for corneal, renal and pancreas/kidney transplants will be reimbursed in the same manner as other non-transplant related physician services.

Other Covered Transplant Services

Physician services relating to other covered transplant surgery procedures (does not include corneal, renal, pancreas/kidney and bone marrow) will be reimbursed at the lesser of negotiated rates or 80% of billed charges. Physician reimbursement at the lesser of negotiated rates or 80% of billed charges is applicable for all allowable physician services relating to the other covered transplant from the date of the transplant procedure to the date of discharge. Physician reimbursement at the lesser of negotiated rates or 80% of billed charges will be reimbursed for the same dates of service as are allowed for hospital services for other covered transplants (See Section 4.19-A). For hospitals, transplant related days in excess of transplant length of stay averages must be approved through medical review. Transplant length of stay averages by each transplant type will be determined from the most current written Medicare National Coverage Decisions.

Physician services provided prior to the date of transplant will be reimbursed in the same manner as other non-transplant related physician services.

Allowable services provided during dates of readmissions to the same hospital due to complications arising from the original transplant are reimbursed the same as the original transplant services at the lesser of negotiated rates or 80% of billed charges. All excess length of stay approval requirements also apply.

Payment is made directly to the physician or, upon request of the physician, payment is made under the Deferred Compensation Plan.

Participation in the Deferred Compensation Plan by a physician is entirely voluntary. The individual physician's authorization and consent is on file. The physician submits his claim in the usual manner, and after verification, the appropriate amount due the physician is deposited in an account administered by First Variable Life Insurance Company or The Variable Annuity Life Insurance Company up to the maximum amounts allowed by the Revenue Act of 1978. Each account in the investment funds is individualized as to each physician participating. Arkansas Division of Medical Services has no responsibility for management or investment of these funds. Federal matching is not claimed for any part of the administration of the Plan. This is a service designed to increase the number of participating physicians in the Medical Assistance Program.

Desensitization injections - Refer to Attachment 4.19-B, 4.b. (15).

Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us
Telephone (501) 682-8292 TDD (501) 682-6789 or 1-877-708-8191
FAX (501) 682-1197

TO: **Arkansas Medicaid Health Care Providers - Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)**

DATE: **March 15, 2005**

SUBJECT: **PROPOSED - Provider Manual Update Transmittal No. 70**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
217.060 – 217.068	10-13-03	217.060 – 217.069	3-15-05
244.000 – 245.000	10-13-03	244.000 – 245.200	3-15-05
250.710 – 270.714	10-13-03	250.710 – 250.717	3-15-05
272.430 – 272.439	10-13-03	272.430 – 272.435	3-15-05

Explanation of Updates

Section 217.060: This section has been expanded to include generic information regarding organ transplants and to give an overview of Medicaid coverage.

Section 217.061: This section explains Arkansas Medicaid's hospital coverage of bone marrow transplants.

Section 217.062: This section explains Arkansas Medicaid's hospital coverage of corneal transplants.

Section 217.063: This section explains Arkansas Medicaid's hospital coverage of heart transplants.

Section 217.064: This section explains Arkansas Medicaid's hospital coverage of liver transplants.

Section 217.065: This section explains Arkansas Medicaid's hospital coverage of liver/bowel transplants.

Section 217.066: This section explains Arkansas Medicaid's hospital coverage of lung transplants.

Section 217.067: This section explains Arkansas Medicaid's hospital coverage of kidney transplants.

Section 217.068: This section explains Arkansas Medicaid's hospital coverage of pancreas/kidney transplants.

Section 217.069: This section explains Arkansas Medicaid's hospital coverage of skin transplants.

Section 244.000: This section has been included to update the table of procedures that require prior authorization and to add informational text to the introduction. Part B has been updated.

Sections 245.000 through 245.200: These sections are included for informational purposes.

Section 250.710: This section provides an overview of Arkansas Medicaid's organ transplant reimbursement methodologies, effective for dates of service on and after December 3, 2004.

Section 250.711: This section explains Arkansas Medicaid's reimbursement methodology for bone marrow transplants.

Section 250.712: This section explains Arkansas Medicaid's reimbursement methodology for corneal, kidney and pancreas/kidney transplants.

Section 250.713: This section explains Arkansas Medicaid's reimbursement methodology for all other covered organ transplants except for those in in-state pediatric hospitals and in Arkansas state-operated teaching hospitals.

Section 250.714: This section explains Arkansas Medicaid's reimbursement methodology for other covered transplants in in-state pediatric hospitals and in Arkansas state-operated teaching hospitals.

Section 250.715: This section explains Arkansas Medicaid's reimbursement methodologies for organ acquisition related to "other covered transplants."

Section 250.716: This section explains that beneficiaries may not be charged for Medicaid-covered charges in excess of the State's reimbursement.

Section 250.717: This section was formerly section 250.714.

Section 272.430: This section has a new title.

Section 272.431: This section sets forth the requirements for billing for bone marrow transplants.

Section 272.432: This section explains how to bill Medicaid for services related to a living bone marrow donor.

Section 272.433: This section explains how to bill Medicaid for services related to a living kidney donor.

Section 272.434: This section explains how to bill Medicaid for services related to a living donor of a partial liver.

Section 272.435: This section comprises relevant information from former section 272.439.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

Thank you for your participation in the Arkansas Medicaid Program.

_____

Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

217.060 Transplants 3-15-05

A. All transplants require prior approval.

B. Medicaid covers the following transplants for beneficiaries of all ages: bone marrow, corneal, heart, kidney, liver and lung.

C. Medicaid covers the following transplants for beneficiaries under the age of 21 who are participating in the Child Health Services (EPSDT) Program: liver/bowel (effective for dates of service on and after December 3, 2004), pancreas/kidney and skin transplants for burns.

D. Inpatient hospital stays for corneal, kidney, pancreas/kidney and skin transplants are subject to Medicaid Utilization Management Program—MUMP—precertification.

E. Regarding inpatient stays related to all organ transplants *except* bone marrow, corneal, kidney, pancreas/kidney and skin:

1. Hospital days in excess of transplant length of stay averages require medical review and approval by the Quality Improvement Organization (QIO), which is Arkansas foundation for Medical Care, Inc. (AFMC).

2. AFMC's reference sources for organ transplant length-of-stay (LOS) averages are the *Centers for Medicare and Medicaid Services (CMS) Acute Inpatient Prospective Payment System (PPS)*—using the "Arithmetic Mean LOS" method—and/or the most recently published *Medicare National Coverage Decisions*.

F. With the exception of cornea, kidney and pancreas/kidney acquisition, Medicaid covers hospitals' organ acquisition costs by means of the reimbursement methodologies explained in detail in section 250.714.

G. With the exception of bone marrow transplants, inpatient days between the admission date and the date of the transplant procedure are subject to MUMP guidelines.

217.061 Bone Marrow Transplants 3-15-05

A. Medicaid covers the following hospital services related to bone marrow transplantation.

1. Hospital services related to harvesting the bone marrow from a living donor.

2. Hospital services related to transplantation of the bone marrow into the receiver.

3. Post-operative services for the donor and the recipient.

B. Inpatient stays for bone marrow transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of admission for the transplant procedure to the date of discharge.

217.062 Corneal Transplants 3-15-05

A. Medicaid covers hospitalization related to corneal transplants from the date of the transplant procedure until the date of discharge, subject to the beneficiary's inpatient benefit utilization status if he or she is aged 21 or older and subject to MUMP precertification requirements.

B. Coverage includes the preservation of the organ from a cadaver donor but not the harvesting of the organ.

217.063 Heart Transplants 3-15-05

A. Medicaid covers the following hospital services related to heart transplantation.

1. Hospital services related to the transplantation of the heart into the receiver.
2. Post-operative services.

B. Inpatient stays for heart transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from AFMC medical review. (See Section 217.060, part E.)

217.064 Liver Transplants 3-15-05

A. Medicaid covers the following hospital services related to liver transplantation.

1. Hospital services related to harvesting a partial organ from a living donor.
2. Hospital services related to the transplantation of the liver (or of a partial liver from a living donor) into the receiver.
3. Post-operative services (including those for the donor, when applicable).

B. Inpatient stays for liver transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from AFMC medical review. (See Section 217.060, part E.)

217.065 Liver/Bowel Transplants 3-15-05

A. Effective for dates of service on and after December 3, 2004, Medicaid covers liver/bowel transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

B. The following hospital services related to liver/bowel transplants are covered:

1. Hospital services related to the transplantation of the liver/bowel into the receiver.
2. Post-operative services.

C. Inpatient stays for liver/bowel transplants are exempt from the MUMP. The services that are excluded from the MUMP are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from AFMC medical review. (See Section 217.060, part E.)

217.066 Lung Transplants 3-15-05

A. The following conditions and diseases are those for which it is believed patients can benefit significantly from a lung transplant when the disease has reached an end-stage cycle or level.

1. Pulmonary vascular diseases:
   a. Primary pulmonary hypertension
   b. Eisenmenger's Syndrome (ASD, VSD, PVA, truncus, other complex anomalies)
   c. Pulmonary hypertension secondary to thromboembolic disease
2. Obstructive lung diseases:
   a. Emphysema (idiopathic)
   b. Emphysema (alpha antitrypsin deficiency)
   c. Bronchopulmonary dysplasia

d. Post-transplant obliterative bronchiolitis
e. Bronchiolitis obliterans organizing pneumonia (BOOP)

3. Restrictive lung diseases:
   a. Idiopathic pulmonary fibrosis
   b. Sarcoidosis
   c. Asbestosis
   d. Eosinophilic granulomatosis
   e. Desquamative interstitial pneumonitis
   f. Lymphangioleiomyomatosis

B. Medicaid covers the following hospital services related to lung transplantation.

1. Hospital services related to the transplantation of the lung into the receiver.
2. Post-operative services.

C. Inpatient stays for lung transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. The services that are excluded from the MUMP and the annual inpatient benefit limit are the covered services provided from the date of the transplant procedure to the date of discharge, subject to any limitations resulting from AFMC medical review. (See Section 217.060, part E.)

217.067 Kidney (Renal) Transplants 3-15-05

A. When a candidate for a renal transplant is not eligible under Medicare, but is eligible under the Medicaid program, Medicaid will cover a prior-approved transplant.

B. Medicaid covers the following hospital services related to renal transplantation.

1. Hospital services related to the surgical procedure for the removal of the organ from a living donor.
2. Hospital services related to the transportation and/or preservation of the organ from a living donor.
3. Hospital services related to the transplantation of the kidney into the receiver.
4. Post-operative services (including those for a living donor, when applicable.)

C. Renal transplants are subject to the same inpatient hospital and outpatient hospital benefit limits (including MUMP) as all other inpatient and outpatient services, for both donor and receiver.

217.068 Pancreas/Kidney Transplants 3-15-05

A. Medicaid covers prior-approved pancreas/kidney transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program who have a diagnosis of juvenile diabetes with renal failure.

B. Inpatient stays for pancreas/kidney transplants are subject to the MUMP.

217.069 Skin Transplants 3-15-05

A. Medicaid covers prior-approved skin transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program who have burns of greater than 70% of the body's surface area with more than 50% of that area being full-thickness or third-degree burns.

B. Medicaid covers the following hospital services related to skin transplantation.

1. Hospital services related to the removal of the skin from the donor site.
2. Hospital services related to the transplantation of the skin.
3. Post-operative services, subject to the limitations of the MUMP.

244.000 Procedures that Require Prior Authorization 3-15-05

A. The procedures represented by the CPT and HCPCS codes in the following table require prior authorization (PA). The performing physician or dentist (or the referring physician or dentist, when lab work is ordered or injections are given by non-physician staff) is responsible for obtaining required PA and forwarding the PA control number to appropriate hospital staff for documentation and billing purposes. A claim for any hospital services that involve a PA-required procedure must contain the PA control number assigned by Medicaid or EDS will deny it.

D9220	J1565	J7340	Q0182	11960	11970	11971	15342
15343	15831	19318	19324	19325	19328	19330	19340
19342	19350	19355	19357	19361	19364	19366	19367
19368	19369	19370	19371	19380	20974	20975	21076
21077	21079	21080	21081	21082	21083	21084	21085
21086	21087	21088	21089	21120	21121	21122	21123
21125	21127	21137	21138	21139	21141	21142	21143
21145	21146	21147	21150	21151	21154	21155	21159
21160	21172	21175	21179	21180	21181	21182	21183
21184	21188	21193	21194	21195	21196	21198	21199
21208	21209	21244	21245	21246	21247	21248	21249
21255	21256	22520	22521	22522	30220	30400	30410
30420	30430	30435	30450	30460	30462	33140	33282
33284	36470	36471	37785	37788	38242	42820	42821
42825	42826	42842	42844	42845	42860	42870	43842
43846	43847	43848	43850	43855	43860	43865	50320
50340	50360	50365	50370	50380	51925	54360	54400
54415	54416	54417	55400	57335	58150	58152	58180
58260	58262	58263	58267	58270	58275	58280	58290
58291	58292	58293	58294	58345	58550	58552	58553
58554	58672	58673	58750	58752	59135	59840	59841
59850	59851	59852	59855	59856	59857	59866	61850
61860	61870	61875	61880	61885	61886	61888	63650
63655	63660	63685	63688	64573	64585	64809	64818
65710	65730	65750	65755	67900	69300	69310	69320
69714	69715	69717	69718	69930	87901	87903	87904
92607	92608	93980	93981				

B. The following revenue codes require prior authorization.

Revenue Code	Description
92393	Ocular prosthesis
0361	Outpatient dental surgery, Group I
0360	Outpatient dental surgery, Group II
0369	Outpatient dental surgery, Group III
0509	Outpatient dental surgery, Group IV

245.000 Prior Approval and Due Process Information 3-15-05

A. Organ transplants in Arkansas and in states that border Arkansas require prior approval from Arkansas Medicaid.

B. In states that do not border Arkansas, organ transplants *and* organ transplant evaluations require prior approval from Arkansas Medicaid.

245.010 Organ Transplant Prior Approval in Arkansas and Bordering States 3-15-05

The attending physician is responsible for obtaining prior approval for organ transplants.

A. The attending physician submits his or her transplant evaluation (workup) results to the Utilization Review (UR) Section, requesting approval of the transplant. **View or print the UR Section contact information.**

B. UR forwards the request and its supporting documentation to Arkansas Foundation for Medical Care, Inc. (AFMC) for a determination of approval or denial.

C. AFMC advises the requesting physician and the beneficiary of its decision.

245.020 Organ Transplant and Evaluation Prior Approval in Non-Bordering States 3-15-05

A. In states that do not border Arkansas, prior approval is required for organ transplant evaluations and organ transplants.

B. The attending physician is responsible for obtaining prior approval for organ transplant evaluations and organ transplants.

1. The attending physician must request from the UR Section prior approval of a transplant evaluation, identifying the facility at which the evaluation is to take place and the physician who will conduct the evaluation. **View or print the UR Section contact information.**
2. UR reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.
3. The evaluation results must be forwarded to UR with a request for approval of the transplant procedure.
4. UR forwards the request and the supporting documentation to AFMC for a determination of approval or denial.
5. AFMC advises the requesting physician and the beneficiary of its decision.

245.100 Requests to Reconsider Denied Prior Approvals 3-15-05

A. Medicaid allows only one reconsideration of a denied approval request.

B. Reconsideration requests that do not include required documentation will be denied automatically.

C. Requests to reconsider transplant prior approval denials must be received by UR within 30 calendar days of the date of the **NOTICE OF ACTION** denial letter. When requesting reconsideration:

1. Return all previously submitted documentation and pertinent additional information to justify the medical necessity of the denied transplant.

2. Include a copy of the **NOTICE OF ACTION** denial letter with the resubmission.

245.200 Beneficiary Appeal Process for Denied Prior Approvals 3-15-05

When DMS or its designee (AFMC in this case) denies a request for prior approval of a transplant or transplant evaluation, the beneficiary may appeal the denial and request a fair hearing.

A. An appeal request must be in writing.

B. The appeal request must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the **NOTICE OF ACTION** denial letter. **View or print the Department of Human Services, Appeals and Hearings Section contact information.**

250.710 Organ Transplant Reimbursement 3-15-05

Effective for dates of service on and after December 3, 2004, Arkansas Medicaid reimburses hospitals for organ transplants in accordance with one of four methodologies.

A. Three of the reimbursement methodologies apply to all in-state acute care/general hospitals, all bordering city hospitals and all out-of-state hospitals, except for in-state pediatric hospitals and Arkansas state-operated teaching hospitals.

B. With the exception of inpatient stays for bone marrow transplants, inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

C. Organ transplant reimbursement methodologies are explained in sections 250.711 through 250.717.

250.711 Bone Marrow Transplants 3-15-05

A. Interim reimbursement for bone marrow transplants is 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed.

1. Total reimbursement for all covered transplant-related services (except any services specifically exempted in this section) may not exceed $150,000.00.

2. Medicaid's remittance includes reimbursement for all covered inpatient hospital services related to the transplant procedure (unless excluded in this section) from the date of admission for the bone marrow transplant procedure to the date of discharge.

B. The hospital claims and the physician claims are manually priced simultaneously after all participating providers have filed their claims.

C. When the combined total of 80% of all participating providers' billed charges exceeds the $150,000.00 maximum allowed reimbursement, each provider's reimbursement is decreased by an equal percentage until the combined total does not exceed the $150,000.00 limit.

D. Medicaid's reimbursement of the medical expenses of a bone marrow donor is not included in the $150,000.00 maximum reimbursement. Providers may submit charges for services related to the donor's participation as those services occur.

E. Medicaid reimbursement for outpatient donor tissue typing is not included in the $150,000.00 maximum reimbursement allowed for bone marrow transplants. Providers may submit charges for outpatient donor tissue typing services as the services occur.

F. Medicaid reimbursement for donor medical transportation related to a bone marrow transplant is not included in the $150,000.00 maximum reimbursement allowed for bone marrow transplants.

250.712 Corneal, Kidney and Pancreas/Kidney Transplants 3-15-05

The Arkansas Medicaid Program reimburses each hospital for inpatient services related to corneal, kidney and pancreas/kidney transplants in accordance with the same methodology that the Program employs to reimburse the hospital for any other inpatient service.

250.713 Other Covered Transplants in all Hospitals Except In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals 3-15-05

A. Hospital services (not including organ acquisition) related to other covered transplant procedures (i.e., all but bone marrow, corneal, kidney and pancreas/kidney) are reimbursed at 45% of submitted charges.

1. Reimbursement includes all medical services related to the covered transplant procedure from the date of the transplant procedure to the date of discharge.

a. Transplant hospitalization days in excess of transplant length-of-stay averages must be approved through Arkansas Foundation for Medical Care, Inc. (AFMC) medical review.

b. Transplant length-of-stay averages for each transplant type will be determined from the most current written *Medicare National Coverage Decisions*.

2. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

B. Medically necessary (as determined by AFMC) readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same methodology as the initial transplant service at 45% of submitted charges.

250.714 Other Covered Transplants in In-State Pediatric Hospitals and Arkansas State-Operated Teaching Hospitals 3-15-05

A. Hospital services provided by in-state pediatric hospitals and Arkansas state-operated teaching hospitals related to other covered transplant procedures (does not include bone marrow, corneal, kidney or pancreas/kidney) are reimbursed in the same manner as other inpatient hospital services with interim reimbursement and final cost settlement.

B. Inpatient hospital days before the transplant date are reimbursed in accordance with the applicable Arkansas Title (XIX (Medicaid) State Plan methodology for the type of hospital in which the transplant is performed.

C. Medically necessary (as determined by AFMC) readmission to the same hospital due to complications arising from the initial transplant is reimbursed in accordance with the same reimbursement methodology as the initial transplant service.

250.715 Organ Acquisition Related to "Other Covered Transplants 3-15-05

Organ transplants other than bone marrow, corneal, kidney and pancreas/kidney are considered "other covered transplants" for the purposes of this rule.

A. Reimbursement for the acquisition of the organ to be transplanted is at:

1. 100% of the submitted organ invoice amount from a third-party organ provider organization or

2. The hospital's reasonable cost with interim reimbursement and year-end cost settlement.

B. The hospital may choose either of the two methods.

1. Under the invoice method, Medicaid will reimburse the hospital 100% of the invoice amount, with no additional reimbursement.

2. Under the interim reimbursement method, Medicaid will remit an interim payment and calculate a year-end cost settlement in a manner consistent with the method used by the Medicare Program for organ acquisition costs.

250.716 Beneficiary Financial Responsibility 3-15-05

The beneficiary may not be billed for Medicaid-covered charges in excess of the State's reimbursement.

250.717 Transportation Related to Transplants 3-15-05

A. Transportation is available for the Medicaid beneficiary through the Arkansas Medicaid Program.

B. Transportation costs are not included in the $150,000.00 maximum reimbursement for bone marrow transplant services.

272.430 Billing for Organ Transplants 3-15-05

A. All associated claims for a transplant evaluation (e.g., physician, lab and X-ray, dental, etc.) must be forwarded to EDS. **View or print EDS Claims Department contact information.**

B. All claims associated with a transplant procedure must be submitted to the Division of Medical Services, Utilization Review (UR) Section. **View or print Utilization Review contact information.** A copy of any third-party payer Explanation of Benefits must be attached to the claim when applicable.

272.431 Billing for Bone Marrow Transplants 3-15-05

All claims associated with a bone marrow transplant must be filed for payment within 60 calendar days from the discharge date of the inpatient stay for the transplant procedure.

A. No claims will be considered for payment after the 60 calendar days have elapsed.

B. If an HIPAA Explanation of Benefits (HEOB) is received from a third-party payer after the 60 calendar days have elapsed, you must forward a copy of the HEOB to the UR Transplant Coordinator.

272.432 Billing for a Living Bone Marrow Donor 3-15-05

You must file a separate claim for the inpatient hospital stay of a living bone marrow donor.

A. If the donor is not an eligible Medicaid beneficiary, file the claim under the eligible Medicaid beneficiary's name and Medicaid ID number.

1. Use ICD-9-CM diagnosis code V59.3 (Donors, bone marrow) for the bone marrow donor.
2. Use ICD-9-CM diagnosis code V70.8 (Other specified general medical examination–examination of potential donor of organ or tissue) for the tissue typing of the donor.

B. If the donor is an eligible Medicaid beneficiary, file the claim under the donor's Medicaid ID number and use the same diagnosis codes listed above.

272.433 Billing for a Living Kidney Donor 3-15-05

You must file a separate claim for the inpatient hospital stay of a living kidney donor.

A. If the donor is not an eligible Medicaid beneficiary, file the claim under the eligible Medicaid beneficiary's name and Medicaid ID number.

1. Use ICD-9-CM diagnosis code V59.4 (Donors, kidney) for the renal donor.
2. Use ICD-9-CM diagnosis code V70.8 (Other specified general medical examination–examination of potential donor of organ or tissue) for the tissue typing of the donor.

B. If the donor is an eligible Medicaid beneficiary, file the claim under the donor's Medicaid ID number and use the same diagnosis codes listed above.

272.434 Billing for a Living Partial-Liver Donor 3-15-05

You must file a separate claim for the transplant-related inpatient hospital stay of a living donor of a partial liver.

A. If the donor is not an eligible Medicaid beneficiary, file the claim under the eligible Medicaid beneficiary's name and Medicaid ID number.

1. Use ICD-9-CM diagnosis code V59.4 (Donors, kidney) for the renal donor.

2. Use ICD-9-CM diagnosis code V70.8 (Other specified general medical examination–examination of potential donor of organ or tissue) for the tissue typing of the donor.

B. If the donor is an eligible Medicaid beneficiary, file the claim under the donor's Medicaid ID number and use the same diagnosis codes listed above.

272.435 Tissue Typing 3-15-05

A. CPT procedure codes **86805**, **86806**, **86807**, **86808**, **86812**, **86813**, **86816**, **86817**, **86821** and **86822** are payable for the tissue typing for both the donor and the receiver.

B. The tissue typing is subject to the $500.00 annual lab and X-ray benefit limit.

1. Extensions will be considered for beneficiaries who exceed the $500.00 annual lab and X-ray benefit limit.

2. Providers must request an extension.

C. Medicaid will authorize up to 10 tissue-typing lab procedures to determine a match for an unrelated bone marrow donor.

Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us
Telephone (501) 682-8292 TDD (501) 682-6789 or 1-877-708-8191
FAX (501) 682-1197

TO: **Arkansas Medicaid Health Care Providers - Physician/Independent Lab/CRNA/Radiation Therapy Center**

DATE: **March 15, 2005**

SUBJECT: **PROPOSED - Provider Manual Update Transmittal No. 91**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
251.300 – 251.308	10-13-03	251.300 – 251.308	3-15-05
261.230	10-13-03	261.230 – 621.232	3-15-05
262.000	10-13-03	262.000	3-15-05
272.800 – 272.830	10-13-03	272.800 – 272.830	3-15-05
292.820 – 292.824	10-13-03	292.820 – 292.832	3-15-05

Explanation of Updates

Sections 251.300 through 251.308: These sections have been revised to delete information not relevant to the coverage of physician services for transplant procedures and to add coverage of liver/bowel transplants for beneficiaries under age 21, effective for dates of service on and after December 3, 2004.

Section 261.230: this section has been rewritten to explain correct procedures regarding prior approval of transplant procedures.

Section 261.231: This section has been added to explain the availability of reconsideration for denied prior approvals and explain the procedures to make a reconsideration request.

Section 261.232: This section has been added to explain a beneficiary's right to appeal an adverse decision.

Section 262.000: This section has been updated to include all procedure codes requiring prior authorization as of March 1, 2005.

Sections 272.800 through 272.830: These sections have been revised to explain the transplant reimbursement methodologies that went into effect for dates of service on and after December 3, 2004.

Sections 292.820 through 292.832: The information in these sections has been updated to reflect the current and correct procedures for physician billing related to organ transplant services. Sections 292.825 through 292.827 are new sections. Portions of all sections were formerly included in section 292.824.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

Thank you for your participation in the Arkansas Medicaid Program.

_____
Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

251.300 Organ Transplants 3-15-05

A. All organ transplants require prior approval.

1. Medicaid covers bone marrow, corneal, heart, kidney, liver and lung transplants for eligible Medicaid beneficiaries of all ages.

2. Medicaid covers pancreas/kidney transplants and skin transplants for burns for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

3. Effective for dates of service on and after December 3, 2004, Medicaid covers liver/bowel transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

B. Medicaid covers physicians' inpatient services only on days that Medicaid covers the hospital's inpatient services; therefore, **it is important that physicians know** that inpatient hospital stays for corneal, kidney, pancreas/kidney and skin transplants are all subject to Medicaid Utilization Management Program—MUMP—precertification.

C. Additionally, for inpatient stays related to all other transplants:

1. Hospital days in excess of transplant length of stay averages require medical review and approval by the Quality Improvement Organization (QIO), which is AFMC.

2. AFMC's reference sources for organ transplant length-of-stay (LOS) averages are the *Centers for Medicare and Medicaid Services (CMS) Acute Inpatient Prospective Payment System (PPS)* – using the "Arithmetic Mean LOS" method – and/or the most recently published *Medicare National Coverage Decisions*.

D. Physicians are reminded that post-operative care (inpatient and/or outpatient) for 10 days is included in Medicaid's coverage of each transplant procedure. In the sections that follow, references to "post-operative care" and "follow-up care" presume the reader's understanding of the 10-day post-operative care rule.

E. Refer to sections 261.100 and 261.230 for prior approval procedures.

F. Refer to sections 292.820 through 292.832 for billing instructions.

251.301 Corneal Transplants 3-15-05

Medicaid covers physician services associated with corneal transplants, subject to the same regulatory guidelines and benefit limits as other covered physician services.

251.302 Kidney (Renal) Transplants 3-15-05

A. If a candidate for a renal transplant is not a Medicare beneficiary but is eligible under the Medicaid Program, Medicaid will cover a prior-approved renal transplant.

B. Covered physician services related to renal transplantation include:

1. Removal of the organ from a living donor.

2. Transplanting the kidney into the receiver.

3. Follow-up care.

C. Physician services for renal transplants are subject to the same regulatory guidelines and benefit limits as other covered physician services for both the donor and the receiver.

251.303 Heart Transplants 3-15-05

A. Medicaid covers heart transplants for beneficiaries of all ages.

B. Covered physician services related to the transplant include:

1. Transplanting the heart into the receiver.
2. Postoperative care.

C. Heart transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published *Medicare National Coverage Decisions* and/or AFMC medical review. Refer to section 251.300 subpart C.

251.304 Liver and Liver/Bowel Transplants 3-15-05

A. Medicaid covers liver transplants for beneficiaries of all ages.

B. Effective for dates of service on and after December 3, 2004, Medicaid covers liver/bowel transplants for beneficiariess under age 21 in the Child Health Services (EPSDT) Program.

C. Covered physician services related to the transplant include:

1. The surgical procedure to remove a partial liver from a living donor (when applicable).
2. Physician services for transplanting the liver into the receiver.
3. Postoperative care (including postoperative care for the living donor of a partial liver, when applicable).

D. Liver and liver/bowel transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published *Medicare National Coverage Decisions* and/or AFMC medical review. Refer to section 251.300 subpart C.

251.305 Bone Marrow Transplants 3-15-05

A. Medicaid covers bone marrow transplants for beneficiaries of all ages.

B. Covered physician services related to bone marrow transplantation include:

1. The bone marrow harvesting procedures.
2. Transplanting the bone marrow into the receiver.
3. Postoperative care for the donor and the receiver.

C. Bone marrow transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge*.

251.306 Lung Transplants 3-15-05

A. Medicaid covers lung transplants for beneficiaries of all ages.

B. The following list of medical diagnoses or diseases are those in which it is believed patients could benefit significantly from a lung transplant when it has been determined the disease has reached an end-stage cycle or level:

1. Pulmonary Vascular Disease
2. Primary Pulmonary Hypertension

3. Eisenmenger's Syndrome (ASD, VSD, PVA, Truncus, Other Complex Anomalies)
4. Pulmonary Hypertension secondary to Thromboembolism
5. Obstructive Lung Disease
6. Emphysema (idiopathic)
7. Emphysema (alpha antitrypsin deficiency)
8. Bronchopulmonary Dysplasia
9. Post Transplant Obliterative Bronchiolitis
10. Bronchiolitis Obliterans Organizing Pneumonia (BOOP)
11. Restrictive Lung Disease
12. Idiopathic Pulmonary Fibrosis
13. Sarcoidosis
14. Asbestosis
15. Eosinophilic Granulomatosis
16. Desquamative Interstitial Pneumonitis
17. Lymphangioleiomyomatosis

C. Covered physician services related to the transplant include:

1. Transplanting the organ into the receiver.
2. Postoperative care.

D. Lung transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published *Medicare National Coverage Decisions* and/or AFMC medical review. Refer to section 251.300 subpart C.

251.307 Skin Transplants 3-15-05

Medicaid covers skin transplants for burns of greater than 70% of the body surface area, with more than 50% of that area being full-thickness or third-degree burns, for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

A. Covered physician services related to the skin transplant include:

1. Removal of the skin from the donor site.
2. Transplanting the skin.
3. Postoperative care.

B. Skin transplants are subject to the MUMP.

251.308 Pancreas/Kidney Transplants 3-15-05

A. Medicaid covers pancreas/kidney transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program who have a diagnosis of juvenile diabetes with renal failure.

B. Covered physician services related to pancreas/kidney transplants include:

1. Transplanting the pancreas/kidney into the receiver.
2. Postoperative care.

C. Pancreas/kidney transplants are subject to the MUMP.

261.230 Prior Approval of Transplant Procedures 3-15-05

A. The attending physician is responsible for obtaining prior approval for organ transplant evaluations and for organ transplants.

1. The attending physician must request from UR prior approval of a transplant evaluation, naming the facility at which the evaluation is to take place and the physician who will conduct the evaluation. **View or print the UR Section contact information.** This request must include the following:

a. History and physical and supporting documentation

b. Previous treatment

c. Copy of the most recent hospitalization

d. Name of proposed facility where patient will be referred for transplant

e. Third-party insurance information, when applicable

2. UR reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.

3. The evaluation results are forwarded to UR with a request for the transplant procedure.

4. UR forwards the request and its supporting documentation to AFMC for a determination of approval or denial.

5. AFMC advises the requesting physician and the beneficiary of its decision.

B. The physician is responsible for distributing documentation of prior approval to the hospital and to the other participating providers, such as the anesthetist, assistant surgeon, etc.

261.231 Reconsideration for Denied Prior Approvals 3-15-05

A. Reconsideration for denied prior approvals may be requested. Any reconsideration request must be received within 30 days of the date of denial notice. When requesting reconsideration of denial, the following information is required:

1. Return a copy of the current NOTICE OF ACTION denial letter with re-submissions.

2. Return all previously submitted documentation as well as additional information for reconsideration.

B. Only one reconsideration is allowed. Any reconsideration request that does not include required documentation will be automatically denied.

261.232 Beneficiary Appeal Process for Denied Prior Approvals 3-15-05

When DMS or its designee (AFMC in this case) denies a request for prior approval of a transplant or transplant evaluation, the beneficiary may appeal the denial and request a fair hearing.

A. An appeal request must be in writing.

B. The appeal request must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the provider notification denial letter from the Utilization Review Section or AFMC. **View or print the Department of Human Services, Appeals and Hearings Section contact information.**

262.000 Procedures That Require Prior Authorization 3-15-05

A. Effective April 1, 2001, procedure codes **22510**, **22521** and **22522** were made payable with prior authorization. Effective March 1, 2005, these procedure codes will be payable without prior authorization.

B. The following procedure codes require prior authorization:

National Codes							
J7320	J7340	S0512	V5014	00170	01964	11960	11970
11971	15342	15343	15400	15831	19316	19318	19324
19325	19328	19330	19340	19342	19350	19355	19357
19361	19364	19366	19367	19368	19369	19370	19371
19380	20974	20975	21076	21077	21079	21080	21081
21082	21083	21084	21085	21086	21087	21088	21089
21120	21121	21122	21123	21125	21127	21137	21138
21139	21141	21142	21143	21145	21146	21147	21150
21151	21154	21155	21159	21160	21172	21175	21179
21180	21181	21182	21183	21184	21188	21193	21194
21195	21196	21198	21199	21208	21209	21244	21245
21246	21247	21248	21249	21255	21256	30220	30400
30410	30420	30430	30435	30450	30460	30462	32851
32852	32853	32854	33140	33282	33284	33945	36470
36471	37785	37788	38240	38241	38242	42820	42821
42825	42826	42842	42844	42845	42860	42870	43842
43843	43846	43847	43848	43850	43855	43860	43865
44132	44133	44135	44136	44232	47135	48155	48160
48554	48556	50320	50340	50360	50365	50370	50380
51925	54360	54400	54415	54416	54417	55400	57335
58150	58152	58180	58260	58262	58263	58267	58270
58280	58290	58291	58292	58293	58294	58345	58550
58552	58553	58554	58672	58673	58750	58752	59135
59840	59841	59850	59851	59852	59855	59856	59857
59866	60512	61850	61860	61862	61870	61875	61880
61885	61886	61888	63650	63655	63660	63685	63688
64573	64585	64809	64818	65710	65730	65750	65755
67900	69300	69310	69320	69714	69715	69717	69718
69930	76012	76013	87901	87903	87904	92081	92100
92326	92393	93980	93981				

Procedure Code	Modifier	Description
E0079	RR	Ambulatory Infusion Device
D0140	EP	EPSDT interperiodic dental screen
L8619	EP	External Sound Processor
V2501		Supplying and fitting Keratoconus lens (hard or gas permeable) - 1 lens
V2501	U1	Supplying and fitting of monocular lens (soft lens) - 1 lens
99202	U2	Low vision services - low vision evaluation

272.800 Organ Transplant Reimbursement 3-15-05

Medicaid covers certain organ transplants with prior approval. Reimbursement for these services is explained in the following sections.

272.810 Bone Marrow Transplant 3-15-05

A. Reimbursement for bone marrow transplants is 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed. Total reimbursement of all covered charges will not exceed $150,000.00. Reimbursement includes all medical services related to the transplant procedure from the date of admission for the bone marrow transplant procedure to the date of discharge. Both the hospital and physician claims will be manually priced simultaneously. If the combined total exceeds the $150,000.00 maximum, reimbursement for each provider type will be decreased by an equal percentage until the combined total does not exceed the maximum dollar limit.

B. The following services are covered but are not included in the $150,000.00 maximum reimbursement:

1. The medical expenses for a related or unrelated donor. Claims must be submitted as services are provided.
2. Transportation for the Medicaid beneficiary is excluded from the $150,000.00 maximum benefit.

272.820 Corneal, Kidney, and Pancreas/Kidney Transplants 3-15-05

Physician services required for corneal, kidney and pancreas/kidney transplants are reimbursed in the same manner as other inpatient and outpatient physician services. The beneficiary may not be billed for Medicaid-covered charges in excess of the State's reimbursement.

272.830 Other Covered Transplants 3-15-05

Effective for dates of service on and after December 3, 2004, physician services relating to other covered transplant surgery procedures will be reimbursed at the lesser of negotiated rates or 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed.

A. Reimbursement based on billed charges is applicable from the date of the transplant procedure to the date of discharge for covered transplant procedures, subject to applicable Medicaid benefit limits, transplant length of stay averages and AFMC medical review.

B. Services provided during dates of readmissions to the same hospital due to complications arising from the original transplant are also reimbursed at the lesser of negotiated rates or 80% of billed charges if determined medically necessary by AFMC review.

C. The beneficiary may not be billed for Medicaid covered charges in excess of the State's reimbursement.

292.820 Organ Transplant Billing 3-15-05

A. All associated claims for a transplant evaluation (e.g., physician, lab and X-ray, dental, etc.) must be forwarded to EDS. **View or print EDS Claims Department contact information.**

B. All claims associated with a transplant procedure must be submitted to the Division of Medical Services, Utilization Review (UR) Section. **View or print Utilization Review contact information.** A copy of any third-party payer Explanation of Benefits must be attached to the claim when applicable.

292.821 Billing for Corneal Transplants 3-15-05

The following CPT procedure codes are payable for corneal transplants with prior approval: **65710, 65730, 65750** and **65755**.

Medicaid will reimburse the physician for the acquisition and preservation of the cornea. Medicaid will not reimburse for the transportation of the cornea. HCPCS procedure code **V2785** (type of service code [paper only] **"1"**) must be used when billing for the acquisition and preservation of the cornea. This code must be billed in conjunction with the transplant surgery. An itemized statement for the acquisition and preservation of the cornea must accompany the CMS-1500 claim form. **View a CMS-1500 sample form.**

292.822 Billing for Renal (Kidney) Transplants 3-15-05

A. The following CPT procedure codes are payable for renal transplants with prior approval: **50320, 50340, 50360, 50365, 50370** and **50380**. CPT procedure code **50300** is non-payable.

1. A separate claim must be filed for the donor. If the donor is not Medicaid eligible, the claim should be filed under the Medicaid beneficiary's name and Medicaid ID number. Diagnosis code V59.4 (Donors, kidney) must be used for the renal donor and diagnosis code V70.8 (Other specified general medical examination - examination of potential donor of organ or tissue) must be used for the tissue typing of the donor.
2. If the donor is a Medicaid beneficiary, the claim must be filed utilizing the donor's Medicaid ID number. However, the diagnosis codes listed above must be used.

B. HCPCS procedure code **A0434 modifier 22** must be used when billing for the transportation and preservation of the cadaver kidney. The physician must bill HCPCS procedure code **A0434 modifier 22** on the claim in conjunction with the transplant surgery. An itemized statement for the transportation and preservation of the kidney must accompany the CMS-1500. **View a CMS-1500 sample form.**

292.823 Billing for Pancreas/Kidney Transplants - Under Age 21 3-15-05

The appropriate CPT procedure code should be used when billing for pancreas/kidney transplantation for individuals under age 21 in the Child Health Services (EPSDT) Program. These procedure codes include **48160**, **48550** and **48554** through **48556**. Procedure codes for allograft preparation are **48550** through **48552**.

Pancreas/kidney transplantation procedure codes require prior approval. The appropriate code(s) may be billed in conjunction when performing the pancreas/kidney transplant procedure. This surgery will be treated as a multiple surgery and will be reimbursed accordingly.

292.824 Billing for Bone Marrow Transplants 3-15-05

A. CPT procedure codes **38240** and **38241** are payable, with prior approval, for a bone marrow transplant.

B. Harvesting procedure codes **38230** and **38231** do not require prior approval and must be used when billing for the donor.

C. All claims associated with a bone marrow transplant must be filed for payment within 60 calendar days from the discharge date of the inpatient stay for the transplant procedure.

1. No claims will be considered for payment after the 60 calendar days have elapsed.

2. If an HIPAA Explanation of Benefits (HEOB) is received from a third-party payer after the 60 calendar days have elapsed, you must forward a copy of the HEOB to the UR Transplant Coordinator.

292.825 Billing for Heart Transplants 3-15-05

CPT procedure code **33945** is payable for a heart transplant. This code requires prior approval.

292.826 Billing for Liver Transplants 3-15-05

CPT procedure code **47135** is payable for a liver transplant. This code requires prior approval.

292.827 Billing for Liver/Bowel Transplants 3-15-05

A. Liver/bowel transplant procedure codes require prior approval.

B. Procedure code **47135** is to be used for the liver.

C. Procedure codes **44135**, **44136**, **44232** and **44133** are to be used for the intestine, as applicable.

292.828 Billing for Lung Transplants 3-15-05

Arkansas Medicaid covers lung transplants (single or double) for beneficiaries of all ages, if deemed medically necessary and prior approved. Use the following procedure codes:

32851 **32852** **32853** **32854**

292.829 Billing for Skin Transplants 3-15-05

Use procedure code **15400** (prior approval required) for a skin transplant procedure. Attach an operative report to the claim.

292.830 General Information for Transplants 3-15-05

A. Providers should not submit charges to Medicaid for payment prior to Medicaid eligibility being established for the patient. Medicaid eligibility is determined by the local Human Services office in the county in which the applicant resides.

B. Refer to sections 251.300 through 251.309 of this manual for coverage information on transplants and section 261.243 for prior authorization instructions.

292.831 Billing for Tissue Typing 3-15-05

A. CPT procedure codes **86805, 86806, 86807, 86808, 86812, 86813, 86816, 86817, 86821** and **86822** are payable for the tissue typing for both the donor and the receiver.

B. The tissue typing is subject to the $500 annual lab and X-ray benefit limit.

1. Extensions will be considered for individuals who exceed the $500.00 annual lab and X-ray benefit limit.

2. Providers must request an extension.

C. Medicaid will authorize up to 10 tissue typing procedures to determine a match for an unrelated donor for a bone marrow transplant.

D. A separate claim must be filed for the tissue typing.

E. Claims for the donor must be forwarded to the Transplant Coordinator.

292.832 Claim Filing for Living Organ Donors 3-15-05

A. A separate claim must be filed for a living donor (related or unrelated).

1. Use diagnosis code V70.8 for the tissue typing claims.

2. When filing claims for bone marrow donors, kidney donors or donors of partial liver, use diagnosis codes V59.3, V59.4 and V59.6, respectively.

B. If the donor is not a Medicaid beneficiary, the claim must be filed under the Medicaid beneficiary's name and ID number.

C. If the donor is a Medicaid beneficiary, the claims must be filed using the donor's name and Medicaid ID number.